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UNITED STATES DISTRICT COURT

MIDDLE DISTRICT OF PENNSYLVANIA

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CYNTHIA ANNE DIVEGLIA

formerly CYNTHIA ANNE KAYLOR,

Plaintiff,

vs. No. 1-CV-00-1342

NORTHWESTERN MUTUAL LIFE

INSURANCE COMPANY,

Defendant.

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ORIGINAL

VIDEOTAPED DEPOSITION OF DR. PATRICK I. BORGEN

New York, New York

Friday, May 21, 2004

Reported by:

THERESA TRAMONDO

JOB NO. 160707B

May, 2004

10:55 a.m.

Videotaped Deposition of DR. PATRICK I. BORGEN, held at the offices of Dr. Borgen, Memorial Sloan-Kettering Cancer Center, 1275 York Avenue, New York, New York, pursuant to Court Order, before Theresa Tramondo, a Notary Public of the State of New York.

A P P E A R A N C E S:

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BY: KIRK WOLGEMUTH, ESQ.

ALSO PRESENT:
CYNTHIA DIVEGLIA
KRISTIN ZARNETSKE, Videographer

IT IS HEREBY STIPULATED AND AGREED, by and between the attorneys for the respective parties herein, that filing and sealing be and the same are hereby waived.

IT IS FURTHER STIPULATED AND AGREED that all objections, except as to the form of the question, shall be reserved to the time of the trial.

IT IS FURTHER STIPULATED AND AGREED that the within deposition may be sworn to and signed before any officer authorized to administer an oath, with the same force and effect as if signed and sworn to before the Court.

(Borgen Exhibit 12, Attending Physician's Statement dated 10/27/99, marked for identification, as of this date.)

(Borgen Exhibit 16, Attending Physician's Statement dated 2/3/98, marked for identification, as of this date.)

(Borgen Exhibit 18, Attending Physician's Statement dated 8/14/98, marked for identification, as of this date.)

(Borgen Exhibit 20, Attending Physician's Statement dated 10/27/99, marked for identification, as of this date.)

(Borgen Exhibit 46, Curriculum Vitae, marked for identification, as of this date.)

(Borgen Exhibit 64, Attending Physician's Statement dated 6/3/97, marked for identification, as of this date.)

THE VIDEOGRAPHER: This is tape number one of the videotaped deposition of Mr. Patrick I. Borgen, M.D., taken by Plaintiff in the matter of Cynthia Anne Diveglia, and formerly Cynthia Anne Kaylor, versus Northwestern Mutual Life Insurance Company, Defendant, in the United States

District Court of the Middle District of Pennsylvania, case number 1-CV-00-1342. This deposition is being held on May 21, 2004, at approximately 10:55 a.m.

My name is Kristin Zarnetske. I'm the legal videographer representing Esquire Deposition Services. The court reporter, also in association with Esquire, is Theresa Tramondo.

This deposition is being held at the office of Dr. Borgen at 424 East 68th Street, New York, New York.

Would counsel present please introduce themselves for the record.

MR. WOLGEMUTH: Kirk Wolgemuth. I represent Northwestern.

MR. DIVEGLIA: Archie Diveglia. I represent Cynthia Diveglia.

THE VIDEOGRAPHER: Would the court reporter please swear in the witness.

DR. PATRICK I. BORGEN, called as a witness, having been duly sworn by a Notary Public, was examined and testified as follows:

EXAMINATION BY

MR. DIVEGLIA:

Q. Doctor, I am Archie Diveglia for Cynthia Diveglia.

Would you state your name and office address, please?

A. Patrick Ivan Borgen, B-O-R-G-E-N. My office address is 1275 York Avenue, New York, New York.

Q. What is your employer, sir?

A. My employer is Memorial Sloan-Kettering Cancer Center.

Q. Would you tell us a little bit about what Memorial Sloan-Kettering Cancer Center is?

A. Briefly, Memorial Sloan-Kettering is the oldest and largest medical facility in the United States dedicated entirely to the prevention, diagnosis and treatment of cancer. It's one of the largest in the world. Our institution is over a hundred and twenty years old.

Q. Would you tell us, sir, what positions you hold at Memorial Sloan-Kettering Cancer Center?

A. I have several positions at Memorial. I'm chief of the surgical breast cancer service in

the Department of Surgery. That makes me the chief breast surgeon here. I also codirect all breast cancer-related clinical activities. I'm chairman of what is called the Breast Cancer Disease Management Team. I also direct the activities of the William F. Keck Breast Research Laboratory. I also hold the position of associate professor of surgery at Cornell University Medical College.

Q. When did you first come to Sloan-Kettering?

A. I came to Sloan-Kettering in 1989 as a clinical fellow.

Q. And have you continued, has your employment been continuous since that time?

A. It has been.

Q. Could you tell us what percentage of your practice is related to breast cancer treatment?

A. 100 percent of my clinical practice and academic practice is breast cancer.

Q. Can you give us an estimate as to the number of breast surgeries you perform in a year?

A. I treat between 275 and 325 patients -- new patients' surgery each year.

Q. And do these surgeries involve invasive cancer?

A. They certainly involve all types of breast cancer. The most common type is invasive cancer.

Q. Would you just -- would you explain to us what invasive cancer is?

A. There are many, many different types of breast cancer, and there are two large families, ductal and lobular, and within those two families we have some breast cancers that are good guys, that don't metastasize. Those are called "in situ." And we have cancers that are capable of escaping the breast. Those are called "invasive."

Q. Just to connect this with Cynthia's case, what type did Cynthia have?

A. Cynthia had an uncommon type of breast cancer that was in the lobular family. The lobular in the breast is the organ that produces milk when a woman is lactating. It is an uncommon site for breast cancers to develop. Fewer than 10 percent of cancers are lobular, and fewer than 5 percent are Cynthia's type. So she had an invasive lobular carcinoma.

Q. Getting back to the invasive cancers that you perform surgeries on, can you give us an estimate over the years how many surgeries that involved invasive cancers have you performed?

A. I would estimate that I've treated between three and four thousand patients with invasive cancer myself, and because not everyone I see comes here, I do some second-opinion work, I've probably seen eight to nine thousand patients with invasive cancer over the years.

Q. Some another physician may have referred somebody here for a consultation, so you have not only your patients but those patients, so we are talking 10 to 12 thousand invasive cases?

A. I would think that eight to ten thousand would be a reasonable estimate.

Q. Do you have any idea or any sense as to how the number of invasive surgeries that you performed compare to other surgeons, what they typically get to see?

A. I know the numbers in New York State where this has been audited. 75 percent of general surgeons in New York State treat fewer than ten breast cancers per year. Because of the unique

nature of this institution, where we are treating in my case nothing but breast cancer, the numbers are extraordinarily higher than the average general surgeon.

Q. Besides your hands-on treatment of breast cancer patients, have you also written articles and textbook chapters on the subject?

A. I have.

Q. You have in front of you a copy of your curriculum vitae; is that correct?

A. Yes.

Q. Now, I don't want to get into it in detail, but could you confirm that you have either written or cowritten over 133 articles relating to breast cancer that have been published?

A. That's correct.

Q. And is it also correct that you've written or cowritten 15 different textbook chapters on breast cancer?

A. That's correct.

Q. And am I correct that you now have approximately ten articles that have been either submitted or in the process of being submitted?

A. At least ten.

Q. Now your CV indicates that you also have cowritten over 124 abstracts; is that correct?

A. That's correct.

Q. Would you briefly tell us what an abstract is?

A. An abstract is a research finding. It is a brief paper that brings a finding to the general public's attention quicker, and so abstracts are presented at national meetings.

Q. And your CV indicates that you are on the editorial board of, I think, 11 different journals; is that right, approximately?

A. That sounds approximately right.

Q. What is your role there, what do you in an editorial capacity?

A. I help to review articles for consideration of publication. In this country we have a very healthy system of peer review, where before something is published a lot of outside eyes look at it and render their opinion about it. Since papers can impact practice, this is an important checks and balance on the system.

Q. So you're reviewing what other physicians have submitted for publication?

A. Right.

Q. We've referenced your curriculum vitae, Exhibit 46; is that a true and correct copy of your curriculum vitae?

A. I believe so.

MR. DIVEGLIA: Cross examination is halt. I pass the witness to counsel.

MR. WOLGEMUTH: Just a few, Dr. Borgen.

EXAMINATION BY

MR. WOLGEMUTH:

Q. The published articles that you've identified, I believe there are approximately 133 of them?

A. I believe that's right.

Q. Do you agree with me, Doctor, that none of those articles discusses any conclusions regarding the effects of stress and risk of recurrence of breath cancer?

A. That is correct.

Q. So you never actually engaged in any type of specific research with respect to that issue?

A. I have not published on that. We have an ongoing audit study looking at a large number of

factors in our large number of breast cancer patients. And certainly stress, psychological issues, social issues, are part of an ongoing work in progress.

Q. But as to this date, you never had any articles published regarding that issue?

A. That's correct.

MR. WOLGEMUTH: That's all I have.

FURTHER EXAMINATION

BY MR. DIVEGLIA:

Q. Doctor, when did Cynthia Kaylor first become your patient?

A. I believe that it was in April of 1997.

Q. When you first saw her, what were your findings, and what did you decide needed to be done?

A. Well, I was concerned about what appeared to be a large tumor in the central part of the breast, and I made recommendations concerning the diagnosis and treatment of that condition.

Q. What were your recommendations?

A. I wanted to do a biopsy, and if that biopsy confirmed my suspicions, I recommended a mastectomy, totally removal of the breast, and

removal of the lymph gland under the left arm.

Q. Did Cynthia Kaylor follow your recommendations?

A. She did.

Q. And when the lymph nodes were removed from under her arm, what were the findings?

A. Unfortunately, every lymph node that I removed contained metastatic invasive lobular breast cancer.

Q. What is a significance of a hundred percent finding of metastatic cancer in a woman's lymph nodes?

A. The lymph nodes under the arm are the most important predictor of the future, and by having every node involved with breast cancer, it made the likelihood of systemic spread quite high.

Q. By "systemic spread" you mean what, sir?

A. What really threatens a woman's health with breast cancer is when it leaves the breast and the lymph nodes and travels in the body. The most common sites are the bone, the lungs and the liver. When breast cancer travels to those organs and establishes itself and becomes a clinical tumor, a tumor we can identify, it is extremely difficult to

cure.

Q. In regard to the -- over the years, the women that you've seen and consulted and performed surgery upon, can you give us an estimate as to the number of women that you know had a hundred percent lymph node involvement?

A. It is thankfully uncommon, and my best estimate would be about one patient a year.

Q. Back in 1997, before you performed the surgery upon her, with the findings that you had upon examination, review of the mammogram films and the like, what was the probability that she was going to have systemic recurrence?

A. Based upon the visit in the clinic or based upon the lymph nodes that we found?

Q. Okay. Just the visit in the clinic without any surgery.

A. Well, the average U.S. woman's risk of being cured of breast cancer, if we took everybody coming through the door, the cure rate is very high, 90, 95 percent. With Cynthia's larger tumor, I might have given her a 70 or 80 percent chance of cure.

Q. Now, once you did learn that there was a

hundred percent lymph node, what was your estimate there as far as recurrence?

A. Yeah. Considerably worse. With maybe an 80 or 90 percent chance of systemic recurrence.

Q. Now, after you performed your radical mastectomy, am I correct, that she then had a regimen -- you recommended a regimen of chemotherapy?

A. I did recommend a regimen of chemotherapy, and I referred her to a colleague of mine in Medical Oncology, who further made recommendations about that treatment.

Q. Can you tell us what is your understanding as to what chemotherapy she incurred?

A. Because of the nature of this breast cancer, Ms. Kaylor was offered a chance to participate in a clinical trial of a more aggressive regimen of chemotherapy, stronger drugs, higher doses and a shorter interval between the doses.

Q. Did she follow the recommendation to have that?

A. She did.

Q. Approximately how long was she

undergoing that program?

A. Approximately six months.

Q. Now, I've heard the term "high-dose intensive"; is that a description of what she had?

A. The treatment that she offered in 1997 is today the standard of care, and we refer to it as "dose-dense," high dose with a short interval between the doses.

Q. What were the side effects of this high dose that she could have incurred and, in fact, that you observed that she did incur?

A. Well, the obvious and striking one is a complete loss of all hair on the body, often a pallor, a lack of color, patients complain of a lack of taste, that food doesn't taste the same, nausea, vomiting, a higher chance of infection. The Taxol can cause numbness and paresthesia in the hands and feet. Adriamycin can weaken the heart muscle. These are the most striking side effects of the chemo.

The other one that is increasingly talked about is an impact on mental functioning. We call it "cognitive functioning," meaning the patient doesn't think as quickly, may not retrieve

a word as quickly, may see a person they know and not pull their name out of the back of their mind. This has been referred to as "chemo brain." It's a terrible name, but that's what it has been called.

Q. Do you have an understanding as to whether Cynthia has incurred these symptoms?

A. I think she incurred almost all of these symptoms. I can't comment on the cardiac toxicity, but certainly in terms of the outward manifestations that I saw, she certainly did.

Q. Is another side effect of chemotherapy extreme fatigue?

A. Yes.

Q. Did she indicate she incurred that?

A. Yes.

And it would have been extremely uncommon given this regimen. We know that virtually a hundred percent of patients on this regimen have extreme fatigue.

Q. After you did your surgery, you referred her for chemotherapy. Did you continue to have follow-up visits with Cynthia?

A. I did.

Q. How often would you see her?

A. Typically it's every six months. Cynthia had a number of doctors looking in on her. My standard approach, and I think this was true with Ms. Kaylor, was every six months.

Q. Do you continue to see her?

A. I do.

Q. After she had completed her dense chemotherapy, do you have any knowledge as to subsequent, whether she was placed on any kind of oral chemotherapies?

A. I do.

Her tumor was responsive to estrogen. Circulating estrogens in her body would promote the growth or regrowth of a cancer, so she was placed on a pill called Tamoxifen citrate, which blocks the effects of estrogen on tumor cells, and I believe she took that for approximately five years.

Q. Do you have any knowledge as to -- subsequent to the Tamoxifen treatment, is she currently on ongoing treatment?

A. While she was on Tamoxifen a study was unblinded that suggested that a follow-up drug may continue to provide some measure of protection. That is a drug in a class of drugs called aromatase

inhibitors. I believe she's on one called Femara.

Q. In the course of your care for her, that she would come to you and ask you to complete disability forms from Northwestern or did Northwestern send you forms for completion; do you recall that?

A. I do.

Q. I have premarked some exhibits. Would you tell us the first one, Exhibit No. 64 -- I think it's dated 6/3/97 on page 2, sir -- is that a form you completed?

A. Yes, it is.

Q. Would you look at item 7-A and note what column comment you made?

A. 7-A is under -- on at the top of the second page, and I indicated "No trial work."

Q. Now, the next exhibit I think I have premarked as Exhibit 16. It's the Attending Physician's Statement that you were asked to complete, dated 2/3/98.

The dates on these are always on the second page, by your name.

A. Yes. I have that in front of me.

Q. And under the section "Extent of

disability," Section F, could you tell us what you wrote and what you then wrote under "Remarks"?

A. Under 6-F the question is "What are the patient's current limitations?" And I wrote "Left arm, no heavy lifting, 10 pound max. See under remarks."

Q. And then what did you say under "Remarks"?

A. Under number 9 under "Remarks," I wrote "A major stress reduction will enhance the likelihood of getting this disease into long-term remission. This may mean a sabbatical from trial work."

Q. The next exhibit I have for you is premarked Exhibit 18. I believe that has a date of 8/14/98; am I correct?

A. The next -- the next one I have is dated '99.

Q. Let's see if I have this.

MR. DIVEGLIA: Would you pass this to the Doctor, please.

MR. WOLGEMUTH: What is the exhibit number?

MR. DIVEGLIA: 18.

Q. Do you have that exhibit in front of you, sir?

A. I do.

Q. Would you tell us what you wrote in 6-F, please?

A. Number 1, "Left arm, no heavy lifting, ten pound max. See remarks."

Q. What did your remarks indicate, sir?

A. Under number 9, "Remarks," I wrote "I continue to recommend major stress reduction. This will enhance the likelihood of a long-term remission."

Q. I think the next exhibit now is Exhibit 12; is that what you have, sir?

A. Yes, it is.

Q. Is that dated 10/27/99?

A. It is.

Q. Would you tell us what is marked under 6-F?

A. "Nonlitigation/nontrial work, stress reduction."

Q. And the last exhibit is Exhibit 20. I think it's dated the same date, but it's a different type of form.

A. That's correct.

Q. Would you tell us, sir, what is listed under 5-B?

A. 5-B I wrote --

Q. I am sorry. Yes, 5-B, yes, sir.

A. "Major stress reduction, nonlitigation, no trial work."

Q. And would you look at item 6-A, please.

A. Yes.

Q. And tell us what you wrote there.

A. The question on the form "Is how long do you anticipate your patient will continue to have work-related restrictions as described in 5-B?" I wrote "Indefinitely."

Q. After that form, did you receive any other forms from Northwestern requesting your opinion regarding the disability?

A. I'm not aware of any.

Q. Now, tell us --

First of all, what, is your knowledge of Cynthia as a trial lawyer, and your knowledge as to what trial lawyers do?

A. Well, within our initial consultation I learned a fair amount about Cynthia and found out

what she did for a living, which was, I believe, medical malpractice-related trial work, litigation. In talking to her I developed an opinion about the type of stresses that were involved in that work. I am married to a trial lawyer, so I had some appreciation of that, what she said resonated with me.

Q. As her physician and surgeon, throughout these years, with the consistent opinion she should not go back to trial work, could you explain to us why you recommended that she not return to trial work?

A. This unfolded as an extremely dangerous, bad type of breast cancer, and I knew that we were going to recommend a variety of treatments. Those treatments are not 100 percent effective, and so we look for other ways to improve the chances of a cure, and one of my own biases, has been stress reduction, and certainly not in every patient, but every patient doesn't have this type of breast cancer. So here from very early on in the management, I felt that we needed to maximize this in every way that we could, and so that's why stress reduction in Cynthia Kaylor.

Q. And in regard to the stress reduction issue, who raised that issue?

A. I did.

Q. And do you make similar recommendations to other patients in high-stress fields?

MR. WOLGEMUTH: Objection.

Q. Was this solely --

MR. WOLGEMUTH: Let's go off the record.

THE VIDEOGRAPHER: The time is 11:20 a.m. We're going off the record.

(Discussion off the record.)

THE VIDEOGRAPHER: The time is 11:21 a.m. We are back on the record.

BY MR. DIVEGLIA:

Q. Doctor, in your clinical practice and in your recommendations that you made to Cynthia, did you have a basis as to whether or not that recommendation would have an effect on her ability to not have a recurrence?

A. Yes, I did. My overwhelming experience over the last 15 years has been that when things look bad, you do everything you can to try to reverse that, and stress reduction has been in my experience a significantly positive thing in terms

of outcome, and conversely, increased stress or lack of stress reduction has -- I very often have seen a negative impact on outcome, and so I said earlier I certainly don't recommend that every patient take off from work and that wouldn't be reasonable, but there are cases like this where I think it's extremely valuable.

Q. Are you aware of whether or not -- other cancer treatment centers have similar programs relating to stress reduction?

A. Certainly all major medical institutions that have cancer programs and certainly cancer centers have a variety of programs to enhance the outcome, one of which is stress management, stress reduction. That's a very, very common thing. Not only in the U.S. but around the world.

Q. You earlier alluded to this about if the cancer reoccurred. Could you just explain to us, if her cancer had reoccurred in, let's say, the five years after her chemotherapy ending, what prognosis would you believe that she would have had?

A. Put bluntly, which is frankly not so easy, we do not have a treatment for breast cancer

that has metastasized and established itself in other organs. We simply don't have tools at our disposal to treat that once it has occurred. It is almost uniformly fatal.

Q. Was there any stage where Cynthia could be determined to be cancer-free or would she always have some cancer in her?

A. Well, I think that the uncertainty of whether there is cancer in her will remain for a long time. She has not had a period during which she's not been treated, since 1998 when the chemo and the Tamoxifen and everything else was done. So she has been under constant treatment since then. With today's technology, it's impossible to determine whether she's actually cancer-free as we sit here today. Time will bear that out.

Q. What is your prognosis for Cynthia at this point?

A. My estimate of Cynthia's prognosis has continued to improve a little bit each year. I am far more optimistic about her prognosis today than I was in 1997, and that will continue to get better.

Q. Earlier you discussed how rare a hundred

percent lymph node involvement is. Do you have an idea as with regard to how many of those women have survived?

A. It's a minority of those women that have survived.

Q. As her physician, who has provided treatment throughout these six or seven years, do you have an opinion whether her following your recommendation to avoid distress of trial work has contributed in any manner as to her lack of reoccurrence?

A. I certainly believe that the combination of everything that was done, thorough surgery, aggressive chemotherapy, aggressive hormonal treatments, stress reduction, have all combined to get her to where she is today.

MR. DIVEGLIA: No further questions.

EXAMINATION BY

MR. WOLGEMUTH:

Q. Good morning, Dr. Borgen.

A. Good morning.

Q. I just have a few questions for you.

Doctor, you had mentioned that your wife was a trial lawyer, I believe?

A. Up until a couple of -- up until baby number four was born.

Q. And Doctor, do you agree with me that the duties of a trial lawyer may be stressful to one attorney and not stressful to another attorney?

A. Sure.

Q. Do you recall whether Mrs. Diveglia had indicated to you when you had first met with her, even over the course of your treatment of her, what particular duties she did that were stressful to her?

A. I don't recall that. My recollection is more a global impression that the practice of law and in particular the practice of litigation was a stressful event for her. I don't remember specific compartmentalizations of the various aspects of her job.

Q. Did you have any discussions with Mrs. Diveglia about the fact that she has cancer and just the stress that that caused her?

A. She told me how much stress or let me know how much stress was involved. I didn't need to ask her that question.

When you sit across the table from

patients who have just been told this news, the stress is palpable. Certainly this stress is then additive to all of life's other stresses.

Q. When you had first met Mrs. Diveglia, did she give you any indication or do you recall any indication of how many times she was in court, how many trials she had a year prior to your diagnosis?

A. We may have had a discussion about that. I simply don't recall.

Q. Doctor, when you counsel your patients who come to see you for treatment of breast cancer, do you direct them to any type of programs or anything like that in terms of stress reduction?

A. Sometimes. Every option -- there are so many different ways to reduce stress, whether it's with a support group, whether it's with a trained healthcare professional, like a psychologist, psychiatrist or psychologist, whether it's with taking a sabbatical from work. Different approaches work in different people, and there are, obviously, risks and benefits to each of those different strategies, including support groups, and so in getting to know the patient, I try to look at

where the most -- if you'll pardon the expression -- bang for the buck is, where can I get the most reduction in stress. For some patients it could be medications, it could be a psychiatrist, it could be support groups. In some people it's stepping away from the stress in their life, whether that's at work or at home.

Q. Would you agree with me, Doctor, that some people that are stressing over the very fact that they have breast cancer, that returning to work could be a positive thing for them in terms of stress reduction?

A. Everyone is different, and I've had patients who I felt should step away from their work for a period of time who didn't, who said, "I'm going to keep working," and certainly all I can do is make recommendations to those people, but clearly in those patients' minds, for whatever reason, they decided to keep working. It certainly happens.

Q. Now, Doctor, on the one Attending Physician's Statement that Mr. Diveglia reviewed with you, I believe you indicated that Mrs. Diveglia should take a sabbatical from trial

work?

A. Uh-hmm.

Q. Do you agree with me that the term "sabbatical" connotes a limited period away from that duty?

A. More than limited. I think it leaves the door open to a return. "Sabbatical" can be two weeks or five years, but it -- I -- my impression was she had a tough hill to climb, and that she, if she successfully climbed that hill and got to the point that she was well down the road, whether it was four years or six years or eight years, my impression, from getting to know her, is that she would return to work, so "sabbatical" to me just left that door open.

Q. Doctor, on your direct examination, I believe you testified about the percent chance of recurrence in somebody that had the level of cancer that Mrs. Diveglia had?

A. Right, I think I was asked that.

Q. What percent was that?

A. Well, I think we talked about it in terms of the chances of the disease metastasizing, and I thought it was 80 to 90 percent.

Q. And would you agree that that risk of 80 to 90 percent would include women that aren't employed?

A. I'm sorry. I'm not sure what you're asking.

Q. I believe you said that the risk of a recurrence in somebody who had the level of cancer that Mrs. Diveglia had is about 80 to 90 percent, and would you agree that that risk would apply to women who have high-stress jobs, low-stress jobs, and no job?

A. Well, no. We're talking about untreated. We're talking about what would happen if I took the cancer out alone and stopped, and so we're talking about taking no action. So that's the -- what we would call the "crude survival rate." That's almost the natural history of breast cancer. If you look at the natural history, yes, it won't -- it won't make a huge difference whether you're working or not. When you begin crossing the line to treating the breast cancer, where you're talking about intervening, taking nodes, giving chemo, giving Tamoxifen, giving Femara, you start looking at incremental benefits in outcome,

incremental benefits in survival. That's what we are talking about here with working versus not working as a stress reduction here. We're talking about the incremental benefit to that, which I think is meaningful.

Q. Now, maybe I misunderstood you, Dr. Borgen. What you're saying is that if you had just done surgery alone, the risk of recurrence would have been 80 to 90 percent?

A. That's right.

Q. So with the chemotherapy that Mrs. Diveglia received, your other patients received, and the other treatment, that reduces the risk of recurrence?

A. That's exactly right.

Q. In somebody like Mrs. Diveglia, that received the chemotherapy that I would understand that you probably prescribed or at least assisted in the prescription of, and the elimination of any sites where you could see invasive cancer, what risk would she have of recurrence after receiving the chemotherapy?

A. The number we typically quote is a 40-to-50 percent reduction in the rate of

metastasis. So if she had a 90 percent rate of metastasis, it would be about 45 percent. Put differently, her survival would go from 10 to about 60 percent.

Q. And somebody that has gone six, seven years since they've had the chemotherapy, and have showed no signs of recurrence, what type of percent would you estimate that she would have a risk of recurrence as of this time?

A. That's a really good question, and a tough question. I think a patient uses up the lion's share of their risk in those first five or six years. With Cynthia I think that there may be still a 10 to 15 percent chance that something could come back. So we've gone from a 90 percent chance to a 10 percent chance. I think that's terrific.

Q. And does that type of prognosis apply to all your patients who remain not cancer-free, but they have no signs of any active metastases after five or six or seven years?

A. Well, you'd have to ask the question does this apply to every patient with 16 nodes positive and that's a really rare subset of

patients, but I think the answer is yes, if we had other patients like Cynthia, who had 16 nodes, who had taken the same steps that she had taken, I think that would be -- that number would be applicable.

Q. Doctor, do you agree with me that after these five or six years had gone by where there has been no evidence that the cancer metastasized, that your belief that she ought to engage in a stress reduction is less important to you?

A. I certainly think that stress reduction is the most beneficial, the higher your risk of recurrence is. Remember, I certainly don't recommend that all of my patients take off of work because most of the time the prognosis is so incredibly good. So yes, as time goes by and as the prognosis begins to brighten, then I do think that the value of stress reduction takes a back seat.

Q. So as of sometime in 1992 or 1993 you wouldn't have had restricted --

A. Two thousand and --

Q. Yes. Sorry.

Sometime during 2002, 2003 you wouldn't

have restricted or placed that restriction upon Mrs. Diveglia?

A. I may not have. I felt that at some point, having gotten to know her over seven years, I felt that at some point she would have come to me and say I think I'm going to return to work. And I certainly would support that. Again, it gets back to the "sabbatical" word. I never envisioned this as long-term disability or long-term being out of work. We just wanted her to have a long-term.

Q. Are you aware, Doctor, that, in fact, Mrs. Diveglia returned to trial work back in December of 2003?

A. I learned that recently.

Q. Doctor, I believe you had testified that maybe there is a 10 percent chance of recurrence of the cancer with somebody like Mrs. Diveglia, that had the level of cancer she had and the fact that she had no evidence of cancer after six or seven years. That 10 percent, in your experience, do you see women that have been working in high-stress jobs over that six- or seven-year period that don't have a recurrence?

A. Well, again, if we go back to the

specific patient that matches Ms. Kaylor, that is the bad breast cancer with high lymph nodes, I am sure there are exceptions to every rule in medicine, but certainly in the aggregate I've seen an improvement in outcome where we could control the stress, absolutely.

Q. And do you agree with me, Doctor, that in some of your patients who had the same level of cancer that Mrs. Diveglia had don't engage in stressful activities and yet, unfortunately, still have a recurrence?

A. Well, certainly, yeah. We -- again, we are looking at all of these steps as incremental benefit, but none of it is perfect, and certainly even with the steps that we took, and even with the stress reduction, we remained worried that the cancer could come back, certainly.

Q. And, Doctor, as of 1998 there has been no evidence that the cancer has recurred in her body?

A. The -- that's correct. The tests we have are incapable of showing whether there is actually cancer cells in her body, but in terms of setting up a metastatic -- we call it a "metastatic

deposit." It means that breast cancer has not only traveled but has begun to grow and proliferate. That's how we describe "metastasis." And that event, thankfully, has not been identified in Ms. Kaylor.

Q. So the bone scans and the CAT scans and blood tests that have been performed show no evidence of metastasis at this point?

A. Right, as we've described, that's right.

Q. Doctor, do you agree with me that your opinion that the reduction of stress could increase the outcome of Mrs. Diveglia, that there is no scientific proof of that opinion?

A. I think it would be extremely difficult to prove measuring stress, quantifying stress, quantifying stress reduction; quantifying the immune system has proven to be very difficult for the medical community, and so in terms of hard core trial, clinical trial, not legal trial, evidence, it has been difficult to do, so I agree with you that that has been difficult. The clinical observation that stress reduction has a good effect is reflected in the fact that every cancer center I know of has a stress reduction program. So you're

correct that the evidence is debatable and soft, and it's necessarily soft. Until we get concrete ways to measure these things, it's going to be tough. But certainly I'm far from alone in the clinical observation that in aggressive bad breast cancers with a guarded prognosis, everything should be done and one of those things should be stress reduction.

Q. Do you agree with me, Doctor, that would be very difficult to quantify or separate the stress from having cancer in the first place versus work-related stress?

A. I think stress is stress. I think it's additive, and certainly there is stress associated, as we discussed earlier. There is certainly a lot of stress with the cancer event itself, absolutely.

Q. And, Doctor, do you agree with me that you've treated patients who have had high-stress positions, were treated for breast cancer and returned to work in their high-stress positions?

A. That has happened, yes.

Q. Would you also agree with me that some of the treating physicians don't restrict their patients from high-stress type of positions after

being treated successfully for breast cancer?

A. Sure. Treatment of this disease is extremely individualized. If we just look at the mainstream options, and I am talking about clinically trial proven options for stage one and two breast cancer, there are 200 treatments we could recommend, all of them sanctioned by the results of the clinical trial. So there is incredible variability in what doctors do. And that's part of the art of breast cancer. So, yes, you would certainly find some doctors who would disagree with this, who would say go about your life, I don't believe in the stress reduction theory, and that certainly is out there.

Q. Doctor, would it be fair to say that having appropriate surgery is by far more important in terms of the long-term prognosis of the patient than stress reduction?

A. Well, I'm a surgeon, so you're asking a loaded question. I think that in the lion's share of breast cancer surgery is the most important option, in situ carcinomas, stage one cancers, node-negative stage two cancers. I certainly think surgery provides the most positive impact on

survival. By the time you reach 16 positive lymph nodes, I think that it's the magic of surgery, plus the medicine, plus everything else that is done.

Q. Do you agree with me, Doctor, that the proper prescription of chemotherapy is also significantly more important in the long-term prognosis of a patient than stress reduction?

A. I think it's the same answer. I think that for early-stage breast cancer, yes, absolutely, the medicines are extremely important, but again as you cross that line to the 16-node positive person, again I think it's the conglomerate of all of the things together.

Q. Doctor, do you know what the National Cancer Institute is?

A. Yes, I do.

Q. Could you explain for the jury what that organization, is?

A. Sure. The National Cancer Institute is a federally established, federally sanctioned organization that is part of a larger body called the National Institutes of Health, or NIH, and the NCI is charged with studying the cancer component of our national healthcare problem. The NIH and

NCI are trying to keep Americans healthier, and it's our tax dollars that pay for this. The NCI does its own research, it funds people like us to do research, and occasionally it produces guidelines or what are called "consensus recommendations," where people in the field have gotten together, put their heads together and issued a statement. So that's sort of the role of the NCI.

Q. And do you agree, Doctor, that I believe the NCI has even funded some research of yours in the past and I believe is currently funding some of your research?

A. It's a very important source of funding for us.

Q. And, Doctor, are you aware of the position of the National Cancer Institute on whether stress reduction would increase the likelihood of no recurrence of cancer?

A. I know that it's a topic that they look at frequently, and I know that it's been the source of attempted studies. Because of what we talked about earlier, that the metrics or the tools are difficult to ascertain, the NCI has concluded that

there is not enough evidence one way or the other to recommend it. They are aiming at the larger body of breast cancer patients. You can imagine the disaster if all the women with breast cancer in America took off of work, for example. There are probably ten million breast cancer survivors in this country right now. There are a quarter of a million new ones each year added to the list.

So the NCI concluded that based on studies that they had, they couldn't recommend it, and I think in the aggregate I certainly would agree with that. Like all government regulations, you have the aggregate and then you have the individuals, and we can't use those federal statements to apply to every single patient, and certainly they were not thinking of someone with 16 positive lymph nodes and a young person with an invasive lobular cancer, with those particular guidelines.

Q. Are you aware of any published recommendations by the National Cancer Institute regarding stress reduction and the risks of recurrence?

A. I'm aware of research that they're

funding, even stress reduction programs that they're funding. So while their statement is "we just can't prove it," they certainly have supported it financially.

Q. Finally, Doctor, do you know who Dr. Barbara Weber is?

A. I do.

Q. What is your professional knowledge of her?

A. Barbara Weber is a researcher who has spent much of her professional life studying the genetics of breast cancer, and most notably two genes, BRCA 1 and BRCA 2.

Q. And in your professional knowledge of her, Doctor, is she respected in the medical community?

A. I think as far as genetics goes, as far as BRCA 1 and 2 go, I think she's absolutely a recognized expert in that field.

Q. Doctor, at this point you're very optimistic about the prognosis for Mrs. Diveglia?

A. It's probably the first time I've said it, but yeah, I am optimistic about it.

MR. WOLGEMUTH: That's all the questions

I have. Thank you, Doctor.

MR. DIVEGLIA: No redirect. We're now complete.

THE VIDEOGRAPHER: The time is 11:50 a.m. on May 21, 2004. This is the end of tape number 1, and this completes the videotaped deposition of Mr. Patrick I. Borgen, M.D.

(Time noted: 11:50 a.m.)

DR. PATRICK I. BORGEN

Subscribed and sworn to before me
this ___ day of _____, 200_.

C E R T I F I C A T E

STATE OF NEW YORK)

: ss.

COUNTY OF NEW YORK)

I, THERESA TRAMONDO, a Notary Public within and for the State of New York, do hereby certify:

That DR. PATRICK I. BORGEN, the witness whose deposition is hereinbefore set forth, was duly sworn by me and that such deposition is a true record of the testimony given by the witness.

I further certify that I am not related to any of the parties to this action by blood or marriage, and that I am in no way interested in the outcome of this matter.

IN WITNESS WHEREOF, I have hereunto set my hand this 27th day of May, 2004.

_____

THERESA TRAMONDO

---------- I N D E X ----------

---------- EXHIBITS ----------